

DMH POLICY

Title: Restraint and Seclusion

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Approval by Commissioner

Signature: Barbara A. Leadholm, M.S., M.B.A.

Date:

I. PURPOSE

The Department of Mental Health (DMH) is committed to eliminating the use of restraint and seclusion. For the purposes of this policy, “restraint” means medication restraint, mechanical restraint and physical restraint. DMH’s regulations at 104 CMR 27.12 set forth the minimum requirements that all facilities must implement to further the goal of preventing the use of Restraint/Seclusion, as well as the legal requirements concerning the use of restraint and seclusion when it is necessary. This policy establishes *additional* requirements for DMH-operated and contracted facilities and programs beyond those established in 104 CMR 27.00. It modifies and incorporates DMH’s March 26, 2004 Philosophy Statement on Restraint and Seclusion. DMH Policy #93-1 is hereby repealed.

II. SCOPE

This policy is applicable to all DMH facilities, which includes DMH-operated and contracted facilities, intensive residential treatment programs (IRTPs) and behaviorally intensive residential treatment programs (BIRTs), that are permitted, pursuant to 104 CMR 27.00, to use restraint or seclusion in emergency situations.

III. PHILOSOPHY STATEMENT

DMH is committed to eliminating the use of restraint or seclusion in its facilities and programs. This goal is consistent with a mental health system that treats people with dignity, respect and mutuality, protects their rights, provides the best care possible, and supports them in their recovery. DMH understands that achieving this goal may require changes in the culture of the clinical environment and the ways in which the physical environment is utilized.

Some individuals enter the mental health system for help in coping with the aftermath of traumatic experiences. Others enter the system in hope of learning how to control symptoms that have left them feeling helpless, hopeless and fearful. Many enter the system involuntarily. Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual's behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.

DMH recognizes that many individuals who have been recipients of mental health services consider restraint and seclusion abusive, violent and unnecessary. For more than 35 years, the consumer/survivor movement has continuously voiced its opposition to restraint and seclusion in documents, forums and protests. This movement has consistently championed the development of gentle, voluntary, empowering and holistic alternatives.

To accomplish the goal of eliminating the use of restraint and seclusion in its facilities and programs, DMH endorses and promotes a public health model that values input from patients, families, staff and advocates, and that emphasizes:

- *Primary Prevention: preventing* the need for restraint or seclusion;
- *Secondary Prevention: early intervention* which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby *reducing* the need for restraint or seclusion; and
- *Tertiary Prevention: reversing or preventing* negative consequences when, in an emergency, restraint or seclusion cannot be avoided.

Furthermore, the public health model uses feedback from each stage to inform and improve subsequent actions. This is a strength-based, patient-driven approach that focuses on enhancing self-esteem, thereby promoting each individual's goals toward recovery. DMH strongly believes this approach is essential in establishing a culture that is proactive, responsive and collaborative, rather than reactive. Comprehensive training, education, modeling, mentoring, supervision and ample support mechanisms foster a therapeutic and healing environment for patients and a supportive environment for staff.

Such a therapeutic and healing environment must take into account the experiences of the patients and staff. Staff must be given opportunities to increase their empathy for and awareness of the patient's subjective and objective experience, including that of mental illness and the physical and emotional impact of restraint and seclusion.

At the same time, while acknowledging the patient's perspective concerning the use of restraint and seclusion and the Department's goal of eventually eliminating their use, and emphasizing that restraint and seclusion are not considered forms of treatment, DMH recognizes that in an emergency situation where less restrictive alternatives have failed, the judicious and humane use of restraint or seclusion may be necessary to prevent the imminent risk of harm. In these instances, staff must use these interventions for the least amount of time and in the least restrictive way, taking into consideration the patient's history, preferences and cultural perspective.

DMH is committed to the continuous evaluation of restraint and seclusion data, and to the ongoing use of targeted performance improvement initiatives. These actions will reinforce the prevention model, improve practice, lead to better outcomes and support the goal of eliminating the use of restraint and seclusion in DMH facilities and programs.

IV. DEFINITIONS

Centers for Medicare and Medicaid (CMS): The federal agency that sets standards for and certifies health care facilities, including mental health facilities for receipt of payment from Medicaid and Medicare.

Health Care Agent: An adult with authority to make health care decisions for another adult under M.G.L. c. 201D.

The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations or JCAHO): A national, private accrediting body for health care organizations, including mental health facilities.

Legally Authorized Representative (LAR): The LAR is a guardian or other fiduciary granted applicable authority by a court of competent jurisdiction, or, in the case of a minor, the parent(s) or other individual or entity with legal custody of the minor.

V. POLICY

The policy elements below are designed to facilitate achievement of DMH's goal to reduce and eventually eliminate the use of restraint and seclusion.

A. Physical Space: A room used for restraint and/or seclusion must be calm, quiet, have appropriate lighting, and afford comfort and maximum privacy to the patient. The facility must assure reasonable bathroom access and provide a reasonable way for the patient to mark the passage of time.

B. Dignity, Privacy and Safety: Staff must make every effort to respect the patient's dignity and privacy, (e.g., maintain the patient's dignity and privacy while he or she is using the bathroom) and ensure the patient's safety while he or she is in restraint or seclusion. The patient should not be observable by visitors or other patients, must be

clothed or covered appropriately at all times, and may be attended only by staff who have been trained in accordance with 104 CMR 27.12(2)(b). The patient must be provided with adequate food, hydration and access to toileting, including feminine hygiene products as needed, and any ingestion of food or liquids must be monitored carefully to avoid the risk of choking and/or aspiration. Interpreter services, including American Sign Language (ASL), shall be provided if necessary and if the patient communicates using ASL, he or she shall, to the extent practical, be placed in a position where he or she is able to see staff and use his or her hands to communicate during the restraint or seclusion.

C. Use of Mechanical and Physical Restraints: The determination as to which mechanical and/or physical restraints should be used must take into consideration a number of factors, including patient preference, the patient's individual crisis prevention plan, medical safety and comfort.

Only staff with specific, current training and demonstrated competency as required in Section V.E. below in the use of these restraints or techniques may be involved in their application. Listed below are descriptions of specific primary and specialty restraints and techniques which can be used under certain conditions. These are the only restraints and techniques that have been approved by DMH for use pursuant to this policy. Improved restraints or techniques developed subsequent to the date of this policy may be used if approved by the Commissioner or his or her designee.

Primary Mechanical Restraints: A mechanical restraint of five (5) points or less, a Safety Coat or a Papoose Board are the primary mechanical restraints to be used when a mechanical restraint is authorized by a physician or nurse pursuant to 104 CMR 27.12.

Specialty Mechanical Restraints Requiring Prior Approval: If the primary restraint has not been effective or the patient has special safety needs which cannot be met by the primary restraint, specialty mechanical restraints may be used. These include the Posey Vest, Geri Chair and Mitts, but specifically exclude **Protective Ambulatory Devices (PADS)**. Prior approval for the use of specialty mechanical restraint must be obtained except in situations where the immediate use of a specialty mechanical restraint is necessary to maintain the safety of patients or staff. Prior approval requires the attending psychiatrist or designee to: (1) obtain approval from the Area Medical Director, Facility Medical Director, COO/Center Director and Director of Nursing or each of their designees; (2) consult with the facility's Human Rights Officer (HRO) and Peer Specialist, if available; and (3) document this process in the patient's treatment plan and Individual Crisis Prevention Plan. The reasons for the use of specialty mechanical restraint without prior approval as described in this paragraph must be documented in the patient's medical record and reported to Area Medical Director, Facility Medical Director, COO/Center Director and Director of Nursing or each of their designees and the facility's HRO and Peer Specialist; prior approval must be sought for possible future use. Approval obtained from the parties listed above for use of a specialty mechanical restraint shall remain in force until or unless it is revoked by one or more of those authorized to give approval or their designees. If the facility's HRO and Peer Specialist were unavailable for prior consultation, the approval of use of specialty mechanical

restraints should be reported to them by the next business day after such approval is obtained. Specialty mechanical restraints require the same degree of monitoring and documentation as primary mechanical restraints.

Physical Restraint: DMH will determine which physical restraint techniques may be used. Such techniques will be included in training for all staff who may be directly involved in a physical restraint. DMH regulations, the Joint Commission and CMS standards will be used to determine what constitutes *physical restraint*. For the purposes of this policy, physical restraint *does not* include:

- holding a patient when necessary for routine physical examinations and/or tests for orthopedic, surgical and other similar medical treatment purposes;
- providing support for the achievement of functional body positioning or proper balance;
- protecting a patient from falling out of bed;
- holding a patient in a way that permits the patient to participate in ongoing activities without the risk of physical harm;
- holding a patient without undue force for the purpose of providing comfort;
- non-forcible holding of a patient's hand/arm to safely escort him/her from one area to another;
- holding a patient when necessary to implement a mechanical or medication restraint;
- holding a patient when necessary to implement a court-ordered treatment (e.g., District Court Section 8B or Probate Court Rogers Order);
- taking reasonable steps to prevent a patient at imminent risk of entering a dangerous situation from doing so with a limited response to avert injury, such as blocking a blow, breaking up a fight, or preventing a fall, a jump, or a run into danger.

Note: Certain of the above may be subject to non-behavioral restraint requirements set forth by the Joint Commission or CMS and may only be used in accordance with those requirements.

D. Procedures and Forms: Each facility must develop and implement procedures to ensure that the following activities and forms are completed and reviewed. Information from these forms (both individual and aggregate) shall be used, as appropriate, to improve clinical practices and administrative processes. The forms shall be distributed and documented in accordance with the regulations and this policy. The procedures must ensure that the Senior Administrative and Clinical Review requirements of 104 CMR 27.12(4)(c) are met. The forms previously used to document "Physician Delay" and "No Specials" are no longer required.

1. *Individual Crisis Prevention Plan:* As soon as possible after admission, as a part of the initial and ongoing assessment and treatment planning process, and in accordance with the procedures developed pursuant to Section D., each facility will collaborate with patients, their LAR, their Health Care Agent, if any, and, where appropriate and authorized, other sources, to identify individual age and patient-specific information for the development of an Individual Crisis

Prevention Plan (sometimes referred to as a “Safety Tool”). Each facility may develop its own format for this plan to meet its particular environment and needs as long as it contains the elements listed below.

The plan shall include, but not be limited to relevant clinical data, such as medical risk factors, physical, learning or cognitive disability, communication needs such as sign language or interpreter, and the patient’s history of trauma. At a minimum, each plan shall include the following elements:

- Identification of triggers that signal or lead to agitation or distress in the patient and, if not addressed, may result in the use of restraint or seclusion;
- Identification of the particular patient-specific approaches and strategies that are most helpful to the patient in reducing agitation or distress (e.g., environmental supports, physical activity, sensory interventions); and
- Identification of patient preferences concerning restraint and seclusion, including type of procedure and positioning, gender of staff that administer and monitor the restraint or seclusion, and supportive interventions that may have a calming effect on the patient.

If a patient chooses not to or is unable to participate in the development of the plan, staff shall develop a plan based on available information until such time as the patient is willing or able to participate in the review and revision of the plan. Staff shall make continuing efforts to include the patient as well as information from other collateral sources in the development of the plan.

The plan shall be revised as necessary to reflect changes in the required elements and shall be reviewed at each treatment plan review and after each incident of restraint or seclusion. Revisions shall include pertinent information from the patient’s previous (patient and staff) debriefing form(s), if any. The Individual Crisis Prevention Plan shall be incorporated into the multidisciplinary treatment plan, which shall be revised accordingly.

Distribution

The facility shall ensure that all staff on all shifts are aware of and have ready access to the Individual Crisis Prevention Plans for their patients. A copy of the plan and all revisions and updates shall be placed in the patient’s medical record. The facility also shall provide each patient with a copy of his or her Individual Crisis Prevention Plan.

2. The Emergency Restraint or Seclusion Form (Part A) shall be completed each time a restraint or seclusion is initiated or renewed. All data elements, including names and signatures on the form, must be completed at the time of the event. Use of Part A is required for all types of restraints, including medication only. The Monitoring and Assessment Form (Part B), which is required for use during a mechanical or physical restraint, or seclusion, shall be completed by the nurse/trained staff assigned to the patient’s care during the time restraint or

seclusion is in process. Although not required, use of Part B is encouraged during a medication (only) restraint.

Distribution

A copy of the form (Parts A and B) shall be filed in the patient's medical record, one copy shall be attached to the Patient Debriefing and Comment Form, and one copy shall be sent to the Commissioner or designee and HRO as part of the facility's monthly reporting requirements (104 CMR 27.12 (5)(i) 2 and 3). The forms must be distributed as required by each facility's procedures.

3. *The Patient Debriefing and Comment Form:* Within 24 hours of the conclusion of the restraint or seclusion event, the patient must be offered an opportunity to debrief and comment on the episode. Patients may include others of their choosing (e.g., a family member, friend, HRO or advocate) in the debriefing process. At a minimum, staff will give the Patient Debriefing and Comment Form, with the Emergency Restraint and Seclusion Form attached, to the patient, and provide the patient with the necessary assistance to help the patient complete it, either in writing or verbally. The Patient Debriefing and Comment Form will be used to document the components of 104 CMR 27.12 (4)(b). If the patient chooses not to respond initially, staff will re-offer the form at least one more time within the 24-hour time frame. If the patient ultimately chooses not to respond, this decision must be documented on the form. Observance of the 24-hour timeframe to complete the form should not preclude continuing clinically appropriate efforts by staff to engage patients in the process of talking about the incident.

Distribution

Upon completion of the debriefing and comment process with the patient, the form shall be placed in the patient's medical record with copies forwarded to the Treatment Team and HRO and, in addition, shall be distributed in accordance with regulatory and facility procedures. The Treatment Team and HRO shall use the form for further planning, modification of the treatment plan and future restraint prevention.

Additional Forms and Opportunities

A facility may choose to develop and provide additional forms and/or opportunities for patient debriefing and comment and shall develop processes and procedures for doing so. The purpose of all debriefing and comment activities is to ensure appropriate feedback to clinicians, staff, and the patient; however, the process must be carried out in such a way as to minimize re-traumatization. Patients may include others of their choosing (e.g., a family member, friend, HRO or advocate) in these additional debriefing opportunities.

4. *Staff Debriefing Form:* Each facility must develop procedures and a form to ensure that Staff Debriefing occurs and is documented as soon as possible after the restraint or seclusion event. The content of this form shall be approved by the

Facility Administration and include all the components identified in 104 CMR 27.12(4)(a).

Distribution: The Staff Debriefing form shall be kept with other restraint-related performance review documents, a copy shall be forwarded to the patient's Treatment Team, and additional copies shall be distributed in accordance with the facility's procedures developed in accordance with this Section. A copy of this form shall not be included in the patient's record.

E. Documentation: Each facility must develop a standardized protocol for documenting an incident of seclusion or restraint that meets the regulatory requirements set forth in 104 CMR 27.12(5)(i). The protocol, at a minimum, must include use of the following standard forms:

- (1) the DMH-approved "Emergency Restraint or Seclusion (R/S) Form A" and "Emergency Restraint or Seclusion (R/S) Form B;"
- (2) the DMH-approved "Patient Debriefing and Comment Form" or for contracted facilities, a comment and debriefing form for client use that has been approved by the Commissioner;
- (3) a "Staff Debriefing Form;"

In addition, the protocol must include standards for the content of documentation of the following:

- (4) Senior Administrative Review, if required by 104 CMR 27.12(4)(c) or the facility's performance improvement plan;
- (5) progress note;
- (6) physician's order;
- (7) any information management system designed to track and report on restraint and seclusion data (e.g., MHIS, ORYX);
- (8) analysis and recommendations pursuant to the facility's performance improvement plan.

F. Performance Improvement: Each facility shall have ongoing performance improvement initiatives that address the prevention, reduction and, if possible, elimination of restraint and seclusion. The performance improvement initiatives shall include analysis of both individual and aggregate data, with recommendations for enhanced clinical care, to further reduce the use of restraint and/or seclusion. The analysis and recommendations shall be documented in writing as part of the facility's performance improvement data.

A plan for preventing, reducing and, if possible, eliminating the use of restraint and seclusion, must be in place for each facility and must include goal statements (including areas for improvement), timelines, measurable indicators and outcomes, procedures for monitoring, and provision for a regular review process. As part of the plan, each facility shall specify the titles of senior administrators who will participate in the Senior Administrative Review and when such a review will be required. The composition of the Administrative Review team and the circumstances triggering a review must meet but may exceed the requirements in 104 CMR 27.12(4)(c).

G. Training: Each facility must have a standardized training protocol that meets the regulatory requirements set forth in 104 CMR 27.12(2). DMH facilities must include in their protocol any training modules approved by the Commissioner or his/her designee. Each facility's protocol must specify which staff are authorized to perform 15-minute safety checks (as per 104 CMR 27.12(5)(h)4) and 30-minute assessments (as per 104 CMR 27.12(5)(h)7), the training requirements for particular staff, standards for determining trainees' competency in the training protocol, and a plan for documenting staff training and competencies.

Every staff person who authorizes, administers, orders, applies or monitors any form of restraint or seclusion or assesses for release of a patient in restraint or seclusion must receive training and demonstrate competence in these techniques, in the appropriate application and use of any mechanical device or type of physical restraint, and in appropriate documentation requirements. Such staff are required to participate and demonstrate competency annually in non-violent strategies and de-escalation training, which includes didactic information and a physical demonstration of skills. The training protocol must be reviewed annually and revised if or when new restraint methods are approved.

The training will include but not be limited to:

- (1) Additional training modules that have been developed to meet any facility-specific training needs (e.g., special populations);
- (2) The development and implementation of the Individual Crisis Plan. This must include a sensitization module on the impact on patients of being in a facility or program (facility should consider asking a former patient to do this). This module will emphasize the potentially disturbing impact of discussing the possibility of the patient being restrained or secluded as part of developing the Individual Crisis Plan;
- (3) The use of sensory interventions and therapies;
- (4) Elements required by 104 CMR 27.12(5)(h)4 to perform a 15-minute safety check. These elements include checking and monitoring vital signs (when indicated), comfort, body alignment and circulation, and behavioral status. In addition, training shall include recognition of changes or concerns about the patient's condition or the need for assessment for release such that assessment by a licensed medical clinician (i.e., RN, MD, NP or PA) is required;

- (5) Elements required by 104 CMR 27.12(5)(h)7 to perform a 30-minute assessment for release. This check must be performed by a licensed medical clinician and requires monitoring vital signs, comfort, body alignment and circulation, and behavioral status;
- (6) The appropriate application and use of approved mechanical restraints, including specialty restraints listed in this policy, and physical restraint;
- (7) The experience of restraint and seclusion from the patient's perspective, preferably including a presentation by an individual who has personally experienced restraint or seclusion;
- (8) An opportunity for trainees to experience restraint. While strictly voluntary, training staff should emphasize that this restraint exercise is a valuable tool for staff to increase their empathic understanding of the patient's experience of restraint;
- (9) Documentation requirements.

V. POLICY IMPLEMENTATION

It is the responsibility of each Chief Operating Officer, Unit or Program Director to implement this policy at DMH-operated facilities, DMH/DPH unit(s), DMH-contracted facilities or DMH-contracted programs respectively.

VI. REVIEW OF THIS POLICY

This policy and its implementation shall be reviewed at least every three years, but immediately upon any change to relevant federal or state law or regulation.